Legal aspects of artificial ventilation in children

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In an intensive care unit patients with breath inefficiency is given artificial ventilation that allowed them to function normally. There is an insufficient number of home respirators. When patient come back to his family the doctor can't give them to all of needed.

The duty of administering health services by doctors is both ethical and legal (law-abiding). The doctor is obliged to provide help for ill people. By saying that, we understand helping directed on protecting patient's life and help, or leading to ease their pain. The abandonment of those duties by the doctor leads to various kinds of responsibilities, from which the most painful is the criminal responsibility. A series of circumstances decides which responsibility the doctor will bear.

Analyzing the given actual state, undoubtedly it is important to show the legal bases of the duty of giving health care by the doctors, the bases of responsibility for not giving those services, and also the statutory resolves defining the patient's rights. This will allow answering the question: did the doctor allow to desist his duty by not giving the respirators to people with breath efficiency, what kind of responsibility does this hold and what are the consequences?

I. The legal duty of providing healthcare comes from the legal rule, which main purpose is to protect human life and health, as goods being the basic value, from the point of axiological law bases. Art. 68 of the Polish constitution says, that "it is everybody's right to have his health protected", and "citizens, independently of their financial status are provided equal access, to healthcare by the authorities, financed with public funds". The source of the doctor's duties is mainly art. 30 Of the doctor's and dentist's profession law (dated Dec 5, 1996), according to which "the doctor has a duty

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of providing medical help, in every case, in which the delay in providing it could cause a danger of life loss, heavy injuries or serious health disorder, or in other urgent cases". In the area of detailed laws it is also important to mention: –art 19 par.1 of the health care institutions law from Aug 30 1991, in which the patient's right to receive "medical services responding to the requirements of medical knowledge, and in the situations of limited possibilities (this situation exists in the title case) providing adequate services to use reliable, based on medical criteria procedures setting the access order to those services", art 65 of the health care services financed from public funds law from Aug 27 2004, stating that health insurance is based on the rules of "equal treating and social solidarity, and providing the insured with equal access to the health care services..." Also, the statements of "Doctor's ethical cod" will have an important meaning in this case, especially art.2 stating the *solus aegroti suprema lex esto* rule, meaning "the patient's well-being is the highest law" And so, the polish law provides a wide area of rights in the healthcare and healthcare access area for all of the citizens. Not delivering the duties given by the law on subjects that provide healthcare (first of all by the doctors) causes legal responsibilities. And so, if the patient who needs help in the meaning of providing healthcare services won't get it in the adequate requirements of medical knowledge (in this case connecting to the respiration unit), then we can say about not taking on the treatment by the doctoring the situation, when it was necessary due to the state of the patient's health.

II. The circumstance of the fundamental meaning for establishing the bases of eventual doctor's responsibility for abandoning providing the healthcare service is the conclusion, if in this particular case the doctor was or wasn't so called warrant of person's safety, which health or life was in danger. The doctor is that warrant only when the legal duty of preventing negative consequences on life and health lays on him. Most often, the source of the warrant's function is taking the responsibility for the patient's life willingly by the doctor. When the doctor's duty isn't the consequence of that special relation connecting him with the person in need of help, we are dealing with a general duty. Abandoning of this duty by the doctor causes a legal responsibility equal with other obligations, only for not committing that duty, regardless of the following course of the events. The base of that responsibility is art 162 of penal codex. *For the responsibility for the crime mentioned in art 162 we must deal with three incoming circumstances: –the doctor must be aware of the dangers for the patient –despite of having this knowledge, he makes a decision not to give adequate help to the patient –there was no special duty for taking care after this particular patient by the doctor. The legal responsibility for the doctor being a legal warrant of preventing negative health consequences for the particular patient is differently shaped, if, in connection with not providing healthcare, the patient suffered negative consequences, or just was in a real risk state of suffering them. According to art. 2 "the penal responsibility for crimes committed by abandoning duties, lies also on the person whose duty was to prevent the result" For determining in relation to the warrant doctor the rule being the base of eventual penal responsibility, determining the health re-

sult, which came out of abandoning by the doctor his duties will have the prior meaning. We are talking here of the responsibility coming from art 160 par 2 and 3 of the penal codex (exposing for direct danger of losing health or life). Those situations occur due to the doctor's idleness accelerates the course of patient's illness which, if taken care of, wouldn't cause a threat to his life. Undoubtedly important is for the doctor's responsibility in this case to determine the type of guilt. In the intentional guilt (art 160 par 2) the doctor is aware of his role as a warrant for the endangered person, also with a will of not giving the health service to the patient, also he agrees to the fact, that by abandoning the service he exposes the patient to a direct danger of life or health loss. Undoubtedly, it is hard to imagine that by his abandoning of the service the doctor would want or agree to cause health loss, or even death (excluding euthanasia, art 150). And so, in practice, we will most often deal with unintentional guilt (art 160 par 3 penal codex), for example for unintentionally causing heavy health loss (art 156 par 2 penal codex). The unintentional guilt takes place, when the warrant doctor didn't obey, in his behavior, the safety rules that were required in the specific case and predicted, or could predict the consequences of those behaviors in the form of endangering the patient. The above deliberations show, that doctor's responsibility for abandoning medical treatment is formed depending on the duty that lays on him (the general or particular duty). The actual state, quoted at the beginning, points at a situation, in which the doctor obliged to take care of the patients with breath disabilities, decides to provide medical services just for some of them, and further decides to abandon medical services to the rest of the patients. Thus comes a conclusion that the doctor comes in a role of the warrant doctor, responsible for the patient's health, for who he obliged to provide medical service. So it could be said, that his responsibility in the aspect of abandoning the treatment, which may lead to endangering patients to negative medical consequences. If the doctor was aware, and above all had the will of not providing the respirators for the patients, we can say that was a deliberate action. This unethical proceeding leads to offense against the law and brings penal responsibility on the doctor. Even if he acted unintentionally in that situation, that is, he didn't have the will to endanger the patients, but he didn't preserve the necessary precautions, his behavior doesn't exclude his responsibility. From the practical reasons, also with connection with the rules of doctor's ethics, the second case appears to be more possible to take place in the actual state of facts. That interfering the rules of proper acting, taking precaution, coming from the medical arts, in providing the patients with the respirators, is a real reason for holding the doctor responsible. In the case, when the number of patients suffering from breath disorders on a hospital ward is much higher than the amount of available respirators, then the doctor, being the patient's safety warrant, determines, using the medical criteria, the order of providing this service. So, he must follow rules of safety accordingly to medical ethics and provided criteria.

III. The doctor's actions, leading to abandoning the treatment, could also be a result of a lack of funding in the public institution of healthcare. There is no doctrine or

judicial achievements in this matter, concerning the above deliberations, which seem to have greater meaning mainly in the doctor's duty cases. It is important to answer the following question-could a rejection of providing medical treatment be a base of a legally-penal charge, if for the sake of patients health that service is needed, and the doctor denies basing on the reason, that all contracted services have been already made? If we're dealing with an urgent case, in the meaning of art. 30 of the doctor's and dentist's profession law, then the doctor must provide help even when it is above the contracted limit of medical services, of course within the particular institution's possibilities. If he doesn't provide that service, he is exposed to the penal responsibility. This situation, when we are talking about an obligation conflict that is when, on one hand the doctor is under the art. 30 of the doctor's and dentist's profession law, on the second he is under the employer's pression, who, when the payment can't be assured, orders the doctor to stop all activity. We are dealing here with a collision of two obligations: the financial interest of a health care institution and the patient's life or health. This normalization orders to use adequate resolves in this case, dealing with a higher necessity state, which sense is sacrificing one legal good to protect the other. So the doctor shouldn't be held responsible, if in an urgent situation he commits actions to save patient's life and health, against the financial interests of his institution. He sacrifices a good that is lower than saving peoples lives, what excludes illegalness of his actions. *The other problem is a case when the patient's state requires medical care, but the case is not urgent. This issue requires recalling the law rules defining patient's rights and the doctor's duties, mentioned in art 68 par 2 of the polish constitution, or art 19 of the public healthcare institution law. So precising the constitution's resolve is mentioned in the public health insurance law (dated Feb 6 1997), which is now replaced with the medical services financed from public funds law (Aug 27 2004). According to art 65 of that law the health insurance is based on the rules of "equal treatment and social solidarity", and also "providing for the insured equal access to healthcare services..." Reassuming, laws given above express in a single-meaning way two rules, important for our deliberations: 1. the equal access to healthcare services rule 2. A rule stating to establish an order of giving medical service based on medical criteria in a situation of limited possibilities. The above arguments allow us to say that every patient suffering in this case on breathe disorder has equal rights for acquiring a respirator. But when the number of respirators is lower than the number of patients, the duty of setting the order of access to them using the medical criteria lays on the doctor, the law regulations don't allow worse quality of service. And so in conclusion: from the moment of taking up medical action on the particular patient the doctor has the duty of behaving accordingly to his medical knowledge.

IV. The particular doctor's actions take place in the conditions of a particular health care institution. So if the lack of respirators doesn't allow the doctor to face the challenges of the actual state of knowledge, which also contains the situation where the reason is the lack of institutional funds, then the responsibility for negative results on the patient can't be put on the doctor, which intervened. According to the Highest

Court opinion, the public healthcare service has a duty of including the average level of medical services. HC advices that the estimations should be made carefully, because the medical and law factors are very closely connected with social factors. In its opinion the standing rules give a base to say, that the right to protect the health was and is limited, also from the financial reasons. So, really important matters are the rules of setting the order of access to medical services, in the cases of limited access to them. That order is now set basing only on medical-natured factors, what means that the patient in a worse state should be provided with a medical service before a person in a less serious state of health. Using this rule in reality isn't a simple matter, it brings a lot of doubts, mainly underlining the doctor's role in taking those decisions. And so, if the doctor gives out the respirators to the patients without maintaining the previously set order, then in the case when the negative health consequences appear in the left-out patients, the penal responsibility lies on that doctor. The statement by Andrzej Zoll, polish Commissioner for Civil Rights Protection, stating that doctor's behavior breaks the law only when it's directed against a law protected good, that is, causes a danger for this good or leads to increase the existing endangering (he means no neutralization or decreasing of existing endangering), seems to be true. Likewise as in Poland, all over the world the doctor's job is to protect the life and health of a man. This duty is regulated in every country law system, and comes straight from doctor's ethics rules. Although, there are some cases, when the doctor didn't provide help for the patient, although a direct obligation of providing the patient with a specific health service. Even though cases like this take place in many countries, they are a seldom subject of internal court adjudications, which focus mainly on doctor's art mistakes. Abandonment of treatment by doctors can take a form of passive euthanasia, that is abandonment of using therapeutic resources sustaining patient's life (the drugs, equipment), which leads to patient's death. It takes place in a situation, when the patient's state is defined as terminal (that is the final state of life, a short period leading straight and undoubtedly to death by complications being a result of a fatal illness. Abandonment of treatment on that patient leads to doctor's responsibility, which form and type lead to many doubts. How far is the doctor obliged to sustain the patient's life, in what cases with passive behavior can't we accuse him of murder or penal help refusal? Are there any boundaries like this at all? There is no single meaning answer. It is impossible to define and precisely mention all of the cases, in which the doctor can stop himself from life sustaining activities. Some boundaries must though exist, considering mainly on the interest and suffering of the patient himself, his dignity and autonomy. In reality, taking decisions about the course of doctor's actions in the terminal phase is extremely difficult. On the European ground, for example in Denmark, the doctor can respect the patient's decision and abandon the treatment, although it is a facultative action. However, a dilemma already exists: can the undertaken treatment be abandoned, if it is the patient's will. One thing, in the Dutch law, not undertaking the treatment, to which the doctor is authorized depending on the patient's will, and a different thing is actively acting in the form of abandoning the treatment or disconnecting the medical gear. According to the documents of international law, nobody's life can be taken (art 6 of the Civil Pact, art. 3 General Human Rights

Declaration, art. 4 American Human Rights Convention). Examples of a situation, in which the doctor must take a decision of abandoning the treatment of a patient: the patient suffers of artery occlusion, had a number of operations, the second patient is suffering on past bronchia pneumonia and heart-failure; the treatment can only take place on an intensive care ward. In that situation the doctor must place the patient on such a ward, if there is no other option of sustaining his life. An older, even incurable patient uses the right to be first, before the young patient, when it comes to placing him on the intensive care ward. The international documents about the right to live don't leave the doctor any options, which of these patient's has a greater right for the intensive therapy (it is assumed that medical resources are limited), allowing to sustain the life, because otherwise the fundamental rule banning discrimination would be violated (art 14 of the European Human Rights Convention, Art 2. of the Civil Pact, Art 1. The American Human Rights Convention). In the human rights international law the difference between normal and special medical care resources wasn't codified, there are no definitions for neither of them. The question is-can we assume, that using the reanimation gear on the patient being in a hopeless state, is an abuse of therapeutic resources, till today is without an answer. The doctor's responsibility for abandoning the treatment and damages caused by his fault is shaped differently in every other law system. In the USA the responsibility of the health service managing subject is taken under consideration (HMO-*Health Maintenance Organizations*, PPO-*Preferred Provider Organizations,* POS-*Point of Service Plans*, which play the role of our medical institutions) for the damages caused by the fault of the general medicine doctor. This responsibility is conditioned from the law relation, connecting the doctor with the HMO, or other similar subject. If the doctor is an employee of a HMO, the respondent superior is the base of his insurance responsibility. For using it, it is required, that between the doctor and HMO the dependency relation must exist, in the shape that allows the superior (HMO, PPO, POS) to have control over the actions of the subordinate. Most of the doctors, that provide private healthcare system services, isn't employed on the bases of job relation, gives them the status of independent executives, what though doesn't exclude the service managing subject's responsibility. But the patient must show, that in the underwriter-doctor relation, the HMO could have an influence on the behavior of the subject providing the service. If the doctor was acting alone, the responsibility of the service managing subject is excluded. However, if the HMO could influence the doctor's decision, the underwriter will bear the responsibility on the implied agency theory. The inability of holding the underwriter under civil responsibility based on the respondent superior or the implied agency theory doesn't automatically exclude the underwriter's responsibility for the intentional acts of independent carriers. If the doctor does his job independently, is free from the HMO influence, the patient can only hold the underwriter responsible, basing on the apparent agency rule. It has a use in all situations, in which the HMO causes reasonable suspicion for the patient, that the doctor is an employee of a subject managing medical services. In the case of Gilbert vs. Sycamore Municipal Hospital (156III.2d 511,1993), the court found, that the doctor on an intensive care ward duty is in his eyes an employee of a hospital, which means that he could be taken for responsibility

under the apparent agency theory. Reassuming, the doctor is obliged to provide medical services, if the service is used to cure illness, save life or health, or ease the pain. The way of providing the service must be corresponding with doctor's art rules, established by knowledge and experience. These rules should be above the penal law, connecting the abandonment of the treatment with penal consequences. The ethical norms, bounding the doctor, are the signs for his conscience and fundaments for making the right decisions.

Tab Date of children introduced to home ventilation

Birth date	*Kind of disease*	*ICU income*	*Start home vent.*	*Lifes*
1981	neuro-musculare dystrophy	1994	2000	y
1989	neuro-musculare dystrophy	1998	2002	y
1986	neuro-musculare dystrophy	1992	–	no
1987	peipherial polineurophathy	1997	2000	y
1985	peipherial polineurophathy	1990	–	no
1984	peipherial polineurophathy	1989	–	no
1998	periphrial polineurophathy	2000	2001	y
1985	respirat. failure during spinal trauma	2002	2003	y
1984	respirat. failure during metabolic disease	1988	–	no
1999	respirat. failure during metabolic disease	1999	2001	y